The Work, Health and Disability Consultation  
Ground Floor  
Caxton House  
6-12 Tothill Street  
London SW1H 9NA

Ref: Work, health and disability: consultation 10/02/17

15 February 2017

Dear Sir/Madam,

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The BMA welcomes the opportunity to respond to the consultation on work, health and disability. Please find enclosed our submission.

The BMA believes in the principle that work is good for health and well-being. We recommend that doctors work closely with all interested parties to facilitate their patients’ safe and timely return to suitable and meaningful employment.

Our response identifies where change is needed in order to make this a reality:

- Mental health services and support: whilst many people with mental health conditions can and want to work, their transition to work depends on tailored and continued support.

- The integration of health and welfare support requires changes to fit notes, and the role of health professionals, including GPs and occupational physicians.

- Closing the disability employment gap requires a radical shift amongst employers and key stakeholders. The UK government has major role to play in exercising leadership.
We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Raj Jethwa
Policy Director
BMA Response - Work, health and disability consultation

Chapter 2: Supporting people into work

What does the evidence tell us about the right type of employment support for people with mental health conditions?

The very different ways in which people can be affected by mental health conditions requires tailored help and support for individuals who will have varying capacities to undertake work.

The welfare system needs to respond to individuals who have mental health conditions with care and avoid further stigmatising an already vulnerable group of people.

The BMA believes that increasing knowledge and support for mental health conditions in the workplace, known as ‘mental health literacy’ needs to be improved. More support should be made available to people with mental health conditions who are seeking employment, including within the NHS. Our own research adds to the body of evidence which highlights unemployment as a major risk factor for common mental disorders

The BMA welcomes the UK government’s recent announcement of “a new partnership with employers to improve mental health support in the workplace” The UK government’s emphasis on workplace support for people with mental health conditions and commitment to tackle the discrimination they face at work are highly relevant.

The majority of people with mental health conditions want to work. However many face obstacles in the working environment. There is strong evidence from the national mental wellbeing survey and Chartered Institute of Personnel Development (CIPD) that employees feel unable to discuss mental health issues with their manager and do not feel that their employer

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3 MIND, Transforming employment and back-to-work support for people with mental health problems, December 2014 [mind.org.uk/media/1690126/weve_got_work_to_do.pdf](https://mind.org.uk/media/1690126/weve_got_work_to_do.pdf)
promotes an inclusive climate in relation to mental health issues. This indicates that mental health is still commonly perceived as a ‘hidden disability’.

Many people with mental health problems struggle to access support. The Care Quality Commission’s (CQC) 2016 community mental health survey found that 43 per cent of people who wanted help from NHS mental health services in England to find or remain in employment did not get the support that they needed.

Mental health literacy holds the potential to improve the initial response when people become unwell. This is particularly relevant in cases of ‘presenteeism’ which has been linked to low-level depression and anxiety.

As one of the largest workforces in the UK, the NHS is well placed to lead the way by offering supervisors and managers mental health training, reviewing policies, and positively encouraging people with mental health problems to work for the NHS.

The Improving Access to Psychological Therapies (IAPT) programme can also help to keep people with depression and stress-related illness in work. However there are long waits for IAPT, risking people falling out of work, and their conditions potentially worsening before they can access counselling.

There is a need to more accurately target interventions aimed at helping people with mental health conditions return to work.

Individual Placement and Support (IPS), consisting of intensive individual support to find a job, combined with heavy in-work support, has repeatedly been shown to be the most effective method of helping people with severe mental health problems to achieve sustainable employment. Studies have shown that IPS clients were twice as likely to gain employment and worked for significantly longer than people who were given more traditional vocational

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5 CIPD, Employee Outlook: Focus on mental health in the workplace 2016 [cipd.co.uk/knowledge/culture/well-being/outlook-mental-health](http://cipd.co.uk/knowledge/culture/well-being/outlook-mental-health)
rehabilitation support (“train and place”)\(^8\). Job coaches have a huge role to play in supporting people with mental health conditions into employment. It is critical that both primary and secondary care professionals are provided with the information in order to refer people to coaching services and that the service is sufficiently resourced nationally to meet demands.

We consider it important that in introducing the Green Paper reforms, the UK government gives reassurance to people with the most severe mental health conditions who cannot work, that they will be supported and will not be forced to take up work. The commitment to abolish ESA reassessments for those with life-long severe health conditions with no prospect of improvement, is strongly welcomed.

**Chapter 3: Assessments for benefits for people with health conditions**

*Should the assessment for the financial support an individual receives from the system be separate from the discussion a claimant has about employment or health support?*

GPs have a unique relationship with their patients in which the confidentiality of patient information is vital. Any changes to the assessment process underpinning unemployment support for people with disabilities or long-term health conditions should respect doctors’ legal and ethical duties to promote the interests of their patients and to respect the confidentiality of their personal health information.

It is also important to note that the majority of GPs are not specialists in occupational medicine and are therefore not specifically qualified to make expert judgments about an individual’s capacity to take up employment.

It is vital that the ESA or equivalent assessment process continues to include the expertise of specifically trained medical practitioners. For further suggestions and comments on the ESA assessment process, please see the comments on chapter five below.

**Chapter 4: Supporting employers to recruit with confidence and create healthy workplaces**

*Moving into work*  
*How can existing government support be reformed to better support the recruitment and retention of disabled people and people with health conditions?*

The BMA welcomes the enabling ethos at the heart of the Green Paper. Facilitating disabled people to pursue their career choices and achieve their goals requires early intervention and

\(^8\) Sainsbury Centre for Mental Health, Doing what works: Individual placement and support into employment, 2009 [centreformentalhealth.org.uk/briefing-37-doing](http://centreformentalhealth.org.uk/briefing-37-doing)
support. We are pleased that the DWP and DH plan to take a cross-departmental approach to implementation, working with the Department for Communities and Local Government and the Department for Business, Energy and Industrial Strategy. We recommend similar partnership working is adopted in the devolved nations.

**Education and training**

It is important that the DH and DWP also work closely with the Department for Education (and equivalents in the devolved nations). Schools, further and higher education and training bodies have a vital role to play in the delivery of the Green Paper. They have a huge contribution to make, both in equipping disabled students with the necessary skills and support to progress their career choices. Education institutions can also help to promote a culture of acceptance and inclusivity where people with disabilities are valued and not marginalised. These objectives are critical to fulfilling the vision of the Green Paper.

The BMA hears regularly about discrimination faced by both medical students with disabilities and those with disabilities applying to medical schools (see below for specific examples). We believe that disability should not be a barrier to medical school entry. Medical schools should provide adequate support for medical students with disabilities. In addition the assessment of medical students should be based positively upon competencies and not negatively upon conditions.

It is vital that education bodies take an inclusive, anticipatory approach to fulfilling their duty of reasonable adjustment to students with physical and learning disabilities. This includes providing dedicated resourcing, facilities and programmes for disabled students.

The BMA considers that it is important that many of the practical barriers which affect disabled people completing their medical training should be removed. The General Medical Council’s *Gateways to the Professions* guidance is an extremely helpful resource in helping medical schools to make necessary adjustments.

Specific examples of discrimination faced by students and trainees with disabilities include:

- Difficulties in accessing reasonable adjustments for speciality exams.

- Accessing appropriate foundation training placements. Currently if there is no suitable placement available for disabled trainees at the end of their five- to six-year medical degree, they may be forced to defer their training for up to a year. We suggest that preparation for disabled medical students to undertake placements should begin earlier.

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• Confusion about wheelchair access arrangements for disabled trainees. Due to recent changes, students requiring wheelchairs have two options: either purchasing a wheelchair with NHS funds, which the NHS owns; or accessing funding to purchase their own wheelchair, which they own. The former option may be problematic if the student is undergoing foundation training and rotating to a new placement every three months. If owned by the NHS, the student may have to leave the wheelchair with the trust at the end of the rotation.

We suggest the implications are fully explained to the student, to avoid the cost and inconvenience of purchasing a new chair at every rotation. Employers of disabled trainees need to proactively identify wheelchair users in advance of changeover to make appropriate arrangements, so that the trainee is able to easily access a wheelchair.

Chapter 5: Supporting employment through health and high quality care for all

Improving discussions about fitness to work and sickness certification

How can we bring about better work-focussed conversations between an individual, healthcare professional, employer and Jobcentre Plus work coach, which focus on what work an individual can do, particularly during the early stages of an illness/developing condition?

The BMA believes that the reforms should focus on a less punitive approach to work-related benefits and provide enhanced support to people with a disability seeking to return to work.

GPs are the main source of regular health support for many people with disabilities. However people with health conditions/disabilities looking to take up work may require more specialist occupational health support. Job coaches have a more detailed knowledge of the reasonable adjustments employers are required to make, the availability of Access to Work funding for adjustments, and the availability of welfare support once a disabled person moves into work. They are also more knowledgeable about the local job market. Therefore they are best qualified to match a person with a particular opportunity.

Improvements are needed at the assessment stage, to enable health professionals conducting work capability assessments (WCA) to have a much more accurate and comprehensive view of the claimant’s situation. We believe this would also reduce the number of appeals registered by claimants. This in turn would limit the number of additional requests to GPs for further information from claimants appealing.
How can we ensure that all healthcare professionals recognise the value of work and consider work during consultations with working age patients? How can we encourage doctors in hospitals to consider fitness for work and, where appropriate, issue a fit note?

The BMA believes in the principle that work is good for health and well-being. We recommend that doctors work closely with all interested parties to facilitate their patients’ safe and timely return to suitable and meaningful employment.

GPs, in particular, recognise the value of work and play a big role in supporting people to access work. More focus could potentially be placed in junior doctor training on issuing fit notes in hospital settings. This should clarify the relevant timescales which the notes can cover, to avoid individuals needing to go back to their GP to obtain a note for additional time.

Are doctors best placed to provide work and health information, make a judgement on fitness for work and provide sickness certification? If not, which other healthcare professionals do you think should play a role in this process to ensure that individuals who are sick understand the positive role that work can play in their recovery and that the right level of information is provided?

The BMA’s position is that fit notes need not be completed by a medical professional. We support a change in legislation to allow other health care professionals such as midwives, allied health professionals and nurse practitioners to complete fit notes for patients. This needs to be accompanied by comprehensive information and training, including referral to occupational health services.

We strongly believe that occupational physicians are best placed to provide personalised support enabling individuals with health conditions or disabilities to return to work. This requires earlier and better access to independent occupational physicians.

Regarding the fit note certificate, what information should be captured to best help the individual, work coaches and employers better support a return to work or job retention?

The BMA considers that any reforms to the system should avoid embellishing the Fit Note. GPs report that it is currently relatively easy to use and issue, with sufficient opportunity to write relevant information. Increasing the length and/or complexity would not be helpful and would add unnecessarily to GPs’ workload.
Is the current fit note the right vehicle to capture this information, or should we consider other ways to capture fitness for work and health information? Does the fit note meet the needs of employers, patients and healthcare professionals?

The BMA’s position is that there should be an extension of self-certification for illness from seven to 14 days to reduce the workload burden in primary care.

Ideally, people would have access to health and support earlier in the process. This would enable people with health conditions/disabilities to be referred to occupational medicine sooner and access specialist advice and support to help them return to work more swiftly. Occupational physicians are more likely to have a detailed understanding of the reasonable adjustment duty and they will be used to working with employers in ensuring that adjustments are made to support a successful return to work. This is particularly relevant for those who would be classified ‘may be fit for work’ on the fit note. However, we also understand that the current pressures on primary care frustrate this scenario.

The BMA is concerned that the current process for assessing work capability causes unnecessary distress for people with disabilities. We believe that the computer-based systems used make it very difficult for the health care professionals carrying out the assessments to exercise their professional judgement. We are concerned that these factors lead to some of the most vulnerable and weakest in our society not receiving the support that they need through the Employment Support Allowance (ESA).

Mental health and musculoskeletal services

How should access to services, assessment, treatment and employment support change for people with mental health or musculoskeletal conditions so that their health and employment needs are met in the best possible way?

Although mental health conditions are given consideration within the WCA, further work is required to ensure that those suffering from mental health conditions are guided through the process in a considered manner. Claimants with mental health issues require their conditions to be appropriately highlighted and identified when cases proceed to the appeal tribunal, so that their needs are taken into consideration during this stage. It is vital that these claimants are assessed by doctors or nurses with significant current experience in mental health, and that better training is provided for mental health assessors.

In general, improvements to the training of health care professionals and decision makers are required so that they are more responsive to the needs of people with mental health conditions.
Transforming the landscape of work and health support

*How can occupational health and related provision be organised so that it is accessible and tailored for all? Is this best delivered at work, through private provision, through the health system, or a combination?*

The BMA’s position is that there should be an independent occupational health service (OHS) and it should be freely available to all patients in the UK. The optimum models for an OHS are described in further detail below.

*What has been your experience of the Fit for Work service, and how should this inform integrated provision for the future?*

The BMA welcomed the introduction of the Fit for Work service and its aim to help GPs who are expected to provide high-quality and often complex care services for their patients, despite increased pressure in terms of patient numbers and consultation times. We note that it is predominantly provides a resource for those in work and therefore would not be able to support people out of work.

In particular, where the voluntary scheme is taken up by the patient, it can replace the need for a fit note and free up valuable resource for other patients. However, there has been no published data on usage or impact of the Fit for Work service. It is essential that this information is published before broader decisions about its role and value can be taken.

*What kind of service design would deliver a position in which everyone who needs occupational health assessment and advice is referred as matter of course?*

Widening access to OHS in England requires addressing the alarming fall in the number of qualified occupational physicians and of doctors entering occupational medicine. In 2016 the All Party Parliamentary Group on Occupational Safety and Health noted that in 2002 there were 79 NHS-based trainees and 137 trainees in private sector posts, compared to a total of 74 trainees in 2015. This has led to a fall in the number of specialists. The number fell by almost five per cent during 2010-13 alone.\(^\text{10}\)

Influential reports from the World Health Organization and DWP have emphasised the need for an OHS to be available to all working age populations.\(^\text{11}\) In many European countries an OHS is

\(^{10}\) All Party Parliamentary Group on Occupational Safety and Health, Occupational medical workforce crisis: The need for action to keep the UK workforce healthy


\(^{11}\) WHO, Workers Health: a global plan of action 2007

who.int/occupational_health/publications/global_plan/en/; DWP, Working for a healthier tomorrow:
either incorporated into national health and social services for all working people, or it is mandated in legislation through risk based insurance levies on employers, who are obliged to purchase comprehensive occupational health, rehabilitation, and compensation services from independent providers. Examples of compulsory provision of OHS include Belgium, Finland, France, Germany and the Netherlands. In Spain an OHS is required for those employing over 1,000 workers and in specific industries in Austria and Denmark.

Creating centrally funded NHS training posts and funding an independent OHS would carry extensive benefits. This would:

- Ensure that the service is financed through the NHS, making it accessible to all NHS patients.
- Provide employment protection to occupational health professionals – removing the fear of giving unwelcome advice to professionals.
- Make the speciality more attractive to medical graduates.
- Enhance the quality of the service provided to employees by guaranteeing the independence of the service.
- Create more training posts and therefore increase access to specialist occupational health advice.
- Bring the UK into line with most other EU countries, who provide contractual employment protection to their OH professionals.

In order to alleviate the workforce shortfall, salary protection should also be clarified and better publicised to attract those doctors who may wish to change career.

**Creating the right environment to join up work and health**

*How can we best encourage innovation through local networks, including promoting models of joint working such as co-location, to improve health and work outcomes?*

Generally GP workload pressures and NHS funding constraints have adversely affected innovation. The reality within primary care is that there are shortages of GPs whilst care is being transferred into the community.

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Nevertheless the BMA believes some innovations have the potential to improve patient experience and help manage workload. These will be relevant for some practices but not all.

- Increasing the time GPs have to spend with their patients would provide them with a greater opportunity to explore with disabled patients questions around their working status and their general wellbeing. The BMA’s 2016 report on safe working in general practice explores this further\(^\text{14}\).

- Telephone triage systems appear to be benefitting practices’ ability to manage workload and therefore giving GPs more time with their patients.

In addition, the GP Forward View in England contains commitments to increase the number of GPs and other clinical staff and therefore have the potential to reduce workload. The GPFV and its predecessor, the 10 point plan, have highlighted some innovative approaches around expansion of the GP practice team skill mix, however it remains to be seen how these will work in practice.

- Clinical pharmacists in GP practices – this could help practice workload but also has long term potential to benefit patient experience by improving access to medication. Pilots are being funded by NHS England – access to funding is an option for all practices/groups of practices.

- The BMA has been working with the Chartered Society of Physiotherapy on promoting opportunities for GP practices to employ a physiotherapist. We have developed joint guidance and a calculator for commissioners/providers to assess the cost of employing a physiotherapist\(^\text{15}\).

- The GPFV commits to 3000 mental health practitioners in GP practices. Whilst little tangible progress has been made, this target could potentially result in positive changes that would improve the system in the way that the Green Paper lays out. Expansion of the IAPT programme is taking place via 22 early implementer clinical commission groups (CCGs). The BMA will be monitoring progress.


Other examples of good practice in primary care:

- Partnership with the voluntary sector and service users. The Oxfordshire Mental Health Partnership brings together six local mental health organisations from the NHS and the charity sector. It enables people with mental health conditions to access ongoing support, including coaching from service users, to help them find work, housing and to meet their individual needs.

What is the best way to encourage clinicians, allied health professionals and commissioners of health and other services to promote work as a health outcome?

Investment in occupational medicine is integral to achieving this shift. There is extensive evidence of the benefits of commissioning an independent OHS. A 2008 study identified a nominal return of £4.17 for every £1 employers spent on workplace wellbeing programmes\(^\text{16}\). As an alternative to a centrally funded service, there is scope for CCGs in England to be more proactive and exploit the current flexibility in commissioning - for example to commission an independent OHS locally.

Chapter 6: Building a movement for change: taking action together

How can we bring about a shift in society’s wider attitudes to make progress and achieve long-lasting change?

The business case for diversity is overwhelming and is heavily promoted by the Work Foundation, CBI and leading employers. Campaigns such as the ‘Time to Change’ campaign on mental health awareness have helped to achieve major shifts in public attitudes towards disabled people.

However employers’ attitudes to disabled people do not exist in a vacuum. Realising the vision of the Green Paper and facilitating more disabled people to take up/return to work will require changes in many other aspects of public services and society, including education and training, transport, housing, health and social care.

The socio-economic effects of disability are highlighted in the Green Paper. The BMA believes that consideration should also be given to the effect that national austerity policies, job cuts,

\(^\text{16}\) PWC, Building the case for wellness, 2008

structural unemployment, as well as poor quality jobs, have had on individuals’ health and capacity to work\textsuperscript{17}.

It is important that the welfare reforms strike the right balance. The stated objectives are to remove barriers to disabled people working and help increase their autonomy, income and opportunities.

However, changing the culture will require an overhaul of the benefits system. Our members frequently encounter patients who are confused about the regulations and have been left extremely distressed and in severe financial hardship by the benefits system and appeals process. In too many cases the current system does not encourage people to take up/return to work. Instead claimants’ health and confidence is diminished, and they require extensive help and support to consider work as a viable option.

It is imperative that the reforms avoid pressurising disabled people who may not have worked for long periods of time into inappropriate or poor quality employment, which may worsen their health. Adopting the wrong approach may deter disabled people from seeking work\textsuperscript{18}.

It is vital that the reforms adopt a truly person-centred approach and put in place a package of support tailored to the needs of the individual, including mentoring, coaching, occupational health, and training. At a time when public service budgets are stretched this presents challenges, however it is integral to the goals of the Green Paper.

\textbf{What is the role of government in bringing about positive change to our attitudes to disabled people and people with health conditions?}

\textbf{UK government leadership}

The UK government has a pivotal role to play by fostering an inclusive culture in which disabled people feel valued and empowered in society and in the workplace.

Properly funded public campaigns and awareness raising programmes can lead to major shifts in opinion towards disability. ‘Time to Change’, the campaign against mental health

\textsuperscript{17} BMA, Recognising the importance of physical health in mental health and intellectual disability: Achieving parity 2016

discrimination, has demonstrated a substantial improvement in public attitudes towards people with mental health problems over six years\(^{19}\).

When it comes to tackling employer discrimination, the BMA considers that the UK government should lead by example and raise standards amongst its own workforce and work to change attitudes within the civil service.

There is also huge potential for the NHS as the UK’s biggest employer, to show strong leadership. The BMA welcomes the Workforce Disability Equality Standard (WDES) which will be introduced into the NHS in England from April 2017. The WDES will quantify the experiences of people with disabilities working in the NHS. This initiative follows strong evidence of discrimination against disabled staff in the NHS. Studies have found that disabled staff felt more bullied, in particular from their managers, more pressure to work when feeling unwell and less confident that their organisation acts fairly with regard to career progression relative to non-disabled staff\(^{20}\).

The research also highlights the level of undisclosed data on disability. Although the NHS England staff survey records 17 per cent of staff as having a disability (similar to the level across Britain: 16 per cent). The NHS Electronic Staff Record in England and Wales shows only three per cent of staff having a disability, indicating that staff may still feel uncomfortable disclosing disabilities, possibly because of associated stigma, and negative attitudes at work.

We hope that WDES will tackle the issues underlying the discrimination faced by disabled doctors and other health professionals and encourage the NHS to become a more inclusive, disability-friendly employer.

**Implementation**

The UK government also has a more practical role to play in ensuring that disabled people receive tailored help and support to take up work/return to work.

In addition the BMA recommends that the DWP/DH take great care in communicating the process and reforms involved in implementing the Green Paper to avoid distressing people who may be extremely vulnerable to changes in their employment-related benefits and support.

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Previous reforms have provoked alarm and uncertainty and have been linked to serious adverse mental health consequences for disabled people\(^\text{21}\).

Staff implementing the new assessments need to be fully trained to avoid incorrect decisions which cause considerable stress and anxiety to disabled people\(^\text{22}\). In 2016 the DWP’s own figures revealed that almost 60 per cent of ESA claimants declared ‘fit for work’ were overturned at tribunal\(^\text{23}\).

Whilst the BMA places strong value on work, we also appreciate that many disabled people have been out of work for a long period of time and may have become deskilled, and/or experienced anxiety, depression and other mental health conditions. Emphasis should be placed, not just on employment, but on a range of activities which may benefit the health, welfare and self-esteem of disabled people out of work, including education and training, volunteering and other social activities.

**Could any of the proposals within the green paper potentially have an adverse effect on people with a protected characteristic? If so, which proposal, and which protected group/s are affected? And how might the group/s be affected?**

The BMA would advise that a full equality impact assessment should be carried out before the Green Paper is taken forward as legislation.

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\(^{21}\) Barr D, Taylor-Robinson D, ‘First, do no harm’: are disability assessments associated with adverse trends in mental health? A longitudinal ecological study *Journal of Epidemiology and Community Health* 2016, [jech.bmj.com/content/70/4/339](http://jech.bmj.com/content/70/4/339)
